Supreme Court, U.S.
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No.

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1995

BLUE CROSS AND BLUE SHIELD
OF VIRGINIA,
Petitioner,

— v. —

MARY BAILEY,
Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

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January 8, 1996

68 pp

QUESTIONS PRESENTED

1. Does the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461, as interpreted by this Court in *Firestone*, permit a court to give only slight or even "zero" deference to a fiduciary who has discretion to determine benefits but operates under a conflict of interest?

2. Does the common law doctrine of *contra proferentem*, which construes contractual ambiguities against the drafter, apply to a lawsuit challenging a benefits determination by an ERISA fiduciary who has discretion to determine benefits under the governing plan?

PARTIES BELOW

Petitioner Blue Cross and Blue Shield of Virginia appeared in the court below as defendant-appellant. Respondent Mary Bailey appeared as plaintiff-appellee.

RULE 29.6 LISTING

Blue Cross and Blue Shield of Virginia has no parent companies or affiliates. Its nonwholly owned subsidiaries are Primary Care First, L.L.C., Peninsula Health Care, Inc., and Priority, Inc.

TABLE OF CONTENTS

QUESTIONS PRESENTED i

PARTIES BELOW ii

RULE 29.6 LISTING ii

TABLE OF AUTHORITIES v

OPINIONS BELOW 1

JURISDICTION 2

STATUTE INVOLVED 2

STATEMENT OF THE CASE 3

Factual Background 3

Procedural History 4

The Fourth Circuit's Opinion 5

REASONS FOR GRANTING THE WRIT 7

I. THE DECISION BELOW TO GIVE "SLIGHT, EVEN ZERO" DEFERENCE TO THE DECISION OF AN ERISA FIDUCIARY WHO HAS DISCRETIONARY AUTHORITY TO DETERMINE ELIGIBILITY FOR BENEFITS IGNORES THIS COURT'S DECISION IN *FIRESTONE* AND EXACERBATES A SPLIT IN THE CIRCUITS 7

The *Firestone* Standard 7

The Fourth Circuit's Standard 8

The Conflict in the Circuits 9

Related Circuit Splits 11

Summary 12

II. THE DECISION BELOW TO APPLY THE COMMON LAW *CONTRA PROFERENTEM* DOCTRINE IGNORES *FIRESTONE* AND CONTINUES AN INTOLERABLE CONFLICT ON A MATTER OF NATIONAL IMPORTANCE 13

CONCLUSION 15

APPENDIX A1

TABLE OF AUTHORITIES

Cases

Atwood v. Newmont Gold Co.,
45 F.3d 1317 (9th Cir. 1995) 9-10

Baxter v. Lynn, 886 F.2d 182 (8th Cir. 1989) 11

Bernards v. United of Omaha Life Insurance Co.,
987 F.2d 486 (8th Cir. 1993) 14

Brewer v. Lincoln National Life Insurance Co.,
921 F.2d 150 (8th Cir. 1990),
cert. denied, 501 U.S. 1238 (1991) . . . 13-14, 14 n.2

Brown v. Blue Cross & Blue Shield of Alabama, Inc.,
898 F.2d 1556 (11th Cir. 1990),
cert. denied, 498 U.S. 1040 (1991) 6, 8

Chevron Chemical Co. v. Oil, Chemical & Atomic Workers Local Union 4-447,
47 F.3d 139 (5th Cir. 1995) 10

Davis v. Kentucky Finance Cos. Retirement Plan,
887 F.2d 689 (6th Cir. 1989), *cert. denied*, 495 U.S. 905, *reh'g denied*, 496 U.S. 932 (1990) . . . 11

Doe v. Group Hospitalization & Medical Services,
3 F.3d 80 (4th Cir. 1993) 8

Donatelli v. Home Insurance Co.,
992 F.2d 763 (8th Cir. 1993) 12

Duhon v. Texaco, Inc., 15 F.3d 1302 (5th Cir.), *reh'g denied*, 20 F.3d 471 (5th Cir. 1994) 10

Finley v. Special Agents Mutual Benefit Association, 957 F.2d 617 (8th Cir. 1992) 14

Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989) . . . . . *passim*

Izzarelli v. Rexene Products Co., 24 F.3d 1506 (5th Cir. 1994) 10

Kunin v. Benefit Trust Life Insurance Co., 910 F.2d 534 (9th Cir.), *cert. denied*, 498 U.S. 1013 (1990), *reh'g denied*, 498 U.S. 1074 (1991) 13, 14 n.2

Luby v. Teamsters Health, Welfare & Pension Trust Fund, 944 F.2d 1176 (3d Cir. 1991) 12

Masella v. Blue Cross & Blue Shield of Connecticut, Inc., 936 F.2d 98 (2d Cir. 1991) . . . 14

McGee v. Equicor-Equitable HCA Corp., 953 F.2d 1192 (10th Cir. 1992) 14

Mertens v. Hewitt Associates, 113 S. Ct. 2063 (1993) 12

O'Neil v. Retirement Plan for Salaried Employees of RKO General, Inc., 37 F.3d 55 (2d Cir. 1994) 14

Patterson v. Hughes Aircraft Co.,
11 F.3d 948 (9th Cir. 1993) 14-15

Perry v. Simplicity Engineering,
900 F.2d 963 (6th Cir. 1990) 12

Petrilli v. Drechsel, 910 F.2d 1441 (7th Cir. 1990) . . 11

Phillips v. Lincoln National Life Insurance Co.,
978 F.2d 302 (7th Cir. 1992) 15

Pierre v. Connecticut General Life Insurance Co.,
502 U.S. 973 (1991) 11

Quesinberry v. Life Insurance Co. of North America,
987 F.2d 1017 (4th Cir. 1993) 12

Stoetzner v. United States Steel Corp.,
897 F.2d 115 (3d Cir. 1990) 11

Van Boxel v. Journal Co. Employees' Pension Trust,
836 F.2d 1048 (7th Cir. 1987) 9

Statutes

28 U.S.C. § 1254(1) 2

28 U.S.C. § 1291 5

28 U.S.C. § 1331 4

29 U.S.C. §§ 1001-1461 . . . . . i, 4

29 U.S.C. § 1132(a)(1)(B) 2, 4

29 U.S.C. § 1144(a) 14 n.2

29 U.S.C. § 1144(b)(2)(A) 14 n.2

Miscellaneous

Annotation, 128 A.L.R. Fed. 1 (1995) 12

IN THE

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BLUE CROSS AND BLUE SHIELD
OF VIRGINIA,

Petitioner,

— v. —

MARY BAILEY,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

Petitioner Blue Cross and Blue Shield of Virginia asks this Court to issue a writ of certiorari to review the judgment and opinion entered by the United States Court of Appeals for the Fourth Circuit on October 11, 1995.

OPINIONS BELOW

The Fourth Circuit's opinion, reported at 67 F.3d 53, appears in the Appendix at A1.

The district court's unreported decision to issue a preliminary injunction against Blue Cross appears at A11. The court's decision to grant summary judgment for Bailey, 866 F. Supp. 277, appears at A24. The court's decision not to vacate its earlier opinions as part of a settlement proposal, reported at 878 F. Supp. 54, appears at A39.

JURISDICTION

Bailey brought this suit under 29 U.S.C. § 1132(a)(1)(B). On November 1, 1994, the district court entered summary judgment in her favor and denied Blue Cross's motion for summary judgment.

Blue Cross appealed, and on October 11, 1995, the Fourth Circuit entered a judgment and an opinion affirming the district court. Blue Cross did not seek rehearing but files this petition within 90 days of the Fourth Circuit's judgment.

This Court's jurisdiction arises under 28 U.S.C. § 1254(1).

STATUTE INVOLVED

29 U.S.C. § 1132

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

. . . .

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan . . . .

STATEMENT OF THE CASE

Factual Background

Mary Bailey is a beneficiary of an ERISA plan established by her husband's company, Bailey Enterprises, and administered by Blue Cross. She sued Blue Cross to make it pay for a controversial procedure that was excluded by her health care plan. Bailey, who has breast cancer, demanded payment for a procedure called high dose chemotherapy with peripheral stem cell rescue ("HDC-PSCR"), and Blue Cross declined to pay because the plan specifically excludes the procedure.

Some of today's avant-garde cancer procedures derive from the following conceptual basis. Applying more chemotherapy kills more cancer. But at higher doses, it also kills the patient. Doctors have therefore devised procedures that include not only high doses of chemotherapy but also some type of rescue from the normally fatal effects of those doses. One such procedure is HDC-PSCR.

It involves four steps. First, the patient receives "growth factors" to increase the number of infection-fighting peripheral stem cells (which become white blood cells) in the bloodstream. Second, doctors harvest some of the patient's peripheral stem cells and freeze them for later use. Third, the patient receives high doses of chemotherapy, which kill not only the cancer but also the body's bone marrow, white blood cells, and peripheral stem cells, rendering the patient defenseless against infection. Fourth, doctors try to rescue the patient's immune system by thawing and reinfusing the harvested peripheral stem cells into the patient's body.

Blue Cross declined to pay for Bailey's HDC-PSCR, based on the following exclusion in her plan:

> Autologous bone marrow transplants or other forms of stem cell rescue (in which the patient is the donor) with high dose chemotherapy or radiation are not covered.

(A2) After listing certain narrow exceptions to this exclusion, the plan reemphasizes the exclusion's general applicability:

> Autologous bone marrow transplants or other forms of stem cell rescue (with high dose chemotherapy and/or radiation), for all other cases are not covered. These include but are not limited to the following: . . . Breast cancer . . . .

(A2)

The plan granted Blue Cross the "sole discretion" to determine "the extent to which a Covered Person is entitled to benefits." (A2-A3) Blue Cross exercised that discretion when it denied Bailey's request.

Bailey conceded below that the plan excludes the PSCR portion of the HDC-PSCR procedure. She argued, however, that the plan covers the HDC portion.

Procedural History

On September 13, 1994, Bailey filed this suit under the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, 29 U.S.C. §§ 1001-1461, in the United States District Court for the Eastern District of Virginia. Jurisdiction derived from 29 U.S.C. § 1132(e)(1) and 28 U.S.C. § 1331.

Also on September 13, Bailey moved for a preliminary injunction to enjoin Blue Cross from refusing coverage for

the HDC-PSCR procedure. On September 30, the district court granted Bailey's motion for a preliminary injunction.

On October 11, 1994, Bailey moved for summary judgment, and on October 17, Blue Cross also moved for summary judgment.

On November 1, 1994, the district court granted Bailey's summary judgment motion and denied Blue Cross's. The Court found that the exclusion at issue "undoubtedly . . . excludes the peripheral stem cell rescue when accompanied by high dose chemotherapy." (A31) But the court also found that the plan "did not clearly exclude the HDC." In the court's view, this created an ambiguity, which the court construed against Blue Cross. (A37)

On November 2, 1994, Blue Cross filed a timely notice of appeal to the Fourth Circuit, which had jurisdiction under 28 U.S.C. § 1291. In an attempt to settle the case during the appeal, both parties requested the district court to vacate its rulings in the case. The district court denied this motion on March 6, 1995.

The Fourth Circuit's Opinion

On appeal, the Fourth Circuit affirmed the district court's decision granting summary judgment for Bailey.

The court first addressed "the appropriate measure with which to review Blue Cross's denial of benefits under the ERISA plan it administers." (A5) The court found that Blue Cross has discretionary authority under the plan, but the court then found that Blue Cross operated under a "total" conflict of interest.[1] (A6) Therefore, under the reasoning of

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[1] Blue Cross conceded that under Fourth Circuit precedent its denial decision was not entitled to full deference under *Firestone*. Even so, the Record contains no evidence that any conflict affected Blue Cross's

Brown v. Blue Cross & Blue Shield of Alabama, Inc., 898 F.2d 1556, 1564 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991), the Fourth Circuit found that "'the proper deference to give may be slight, even zero.'" (A6)

Blue Cross noted that the district court had erroneously failed to articulate how much deference Blue Cross should receive. The Fourth Circuit agreed that "a more extensive analysis might have been helpful," but declined to conclude that the district court had erred in not "elaborat[ing] specifically on the degree of deference it considered appropriate." (A6)

Applying this undefined "less deferential standard," the Fourth Circuit agreed with the district court that the plan's exclusion is ambiguous. (A6-A8) Employing the common law doctrine of *contra proferentem*, which courts sometimes invoke to construe a contract's ambiguities against the drafter, the Fourth Circuit found that "the district court's ruling prohibiting Blue Cross from denying coverage for Bailey's high dose chemotherapy was proper as a matter of law." (A8) The Fourth Circuit therefore found no error in the district court's summary judgment for Bailey.

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specific decision to deny Bailey's request for coverage, or that Blue Cross benefited by denying Bailey's request.

REASONS FOR GRANTING THE WRIT

I.

THE DECISION BELOW TO GIVE "SLIGHT, EVEN ZERO" DEFERENCE TO THE DECISION OF AN ERISA FIDUCIARY WHO HAS DISCRETIONARY AUTHORITY TO DETERMINE ELIGIBILITY FOR BENEFITS IGNORES THIS COURT'S DECISION IN *FIRESTONE* AND EXACERBATES A SPLIT IN THE CIRCUITS

The *Firestone* Standard

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 111 (1989), this Court announced that principles of trust law determine the appropriate standard of review for actions under § 1132(a)(1)(B). This Court further explained:

> Trust principles make a deferential standard of review appropriate when a trustee exercises discretionary powers. A trustee may be given power to construe disputed or doubtful terms, and in such circumstances, the trustee's interpretation will not be disturbed if reasonable. Whether "the exercise of a power is permissive or mandatory depends upon the terms of the trust." Hence, over a century ago we remarked that "[w]hen trustees are in existence, and capable of acting, a court of equity will not interfere to control them in the exercise of a *discretion vested in them by the instrument* under which they act."

Id. (citations omitted) (alteration in original).

Applying these principles, this Court held in *Firestone* that a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard *unless* the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to

> construe the terms of the plan. . . . Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be *weighed as a "facto[r]* in determining whether there is an abuse of discretion."

Id. at 115 (citing Restatement (Second) of Trusts § 187, comment d (1959) (alteration in original) (emphasis added)).

Although a conflict of interest is a factor in abuse-of-discretion review, a court still may only examine whether the fiduciary abused its discretion. As this Court emphasized in *Firestone*:

> Where discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is *not* subject to control by the court except to prevent an abuse by the trustee of his discretion.

Id. at 111 (quoting Restatement (Second) of Trusts § 187 (1959) (emphasis added)).

The Fourth Circuit's Standard

The Fourth Circuit ignored this precedent in ruling against Blue Cross. Although the court found that Bailey's plan gives discretion to Blue Cross, the court extended its earlier reasoning in *Doe v. Group Hospitalization & Medical Services*, 3 F.3d 80, 87 (4th Cir. 1993), to find that Blue Cross's decision was "'entitled to some deference, but this deference will be lessened to the degree necessary to neutralize any untoward influence resulting from the conflict.'" (A5-A6) The Court then reasoned that because "Blue Cross stood as the single beneficiary of a substantial sum based on its denial of benefits," it operated under a "total" conflict of interest and, under *Brown*, 898 F.2d at 1564, "'the proper deference to give may be slight, even zero.'" (A6)

Thus, despite *Firestone*'s holding that a conflict of interest should be considered as a *factor* within a court's review for abuse of discretion, the Fourth Circuit held that a conflict of interest would trigger an altogether different *standard* of review and could even lead to *zero* deference. Although admitting that it applied a "less deferential standard" due to the conflict of interest, the Fourth Circuit did not describe that standard or explain how the conflict affected it. (A5-A6) Then, after this cryptic analysis, the Fourth Circuit proceeded to accord zero deference to Blue Cross's decision. (A8)

The Conflict in the Circuits

The Fourth Circuit's ill-articulated standard, which denied Blue Cross the benefit of *any* deference, not only ignores *Firestone* but also continues a confusing split in the circuits.

The Seventh Circuit's approach resembles the Fourth Circuit's. *See, e.g., Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1052-53 (7th Cir. 1987) (finding that the standard of review for decisions made under a conflict should be "more penetrating the greater is the suspicion of partiality, less penetrating the smaller that suspicion is").

The Ninth and Eleventh Circuits dilute *Firestone* even more. Once a claimant demonstrates a conflict of interest, those circuits will apply what is effectively a *de novo* review. As the Ninth Circuit has described the standard:

> If a conflicted fiduciary's interpretation which advances the fiduciary's interest at the expense of the beneficiary is "wrong" under *de novo* review but still "apparently reasonable," the fiduciary has committed an abuse of discretion unless the plan can show that the interpretation was not made to serve its conflicting interest.

Atwood v. Newmont Gold Co., 45 F.3d 1317, 1323 (9th Cir. 1995) (citing *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556, 1566-67 (11th Cir. 1990)). The Ninth Circuit acknowledged that other circuits have adopted "very different formulations of the standard." *Id.*

By contrast, the Fifth Circuit's approach faithfully applies the standard set forth in *Firestone*. In *Duhon v. Texaco, Inc.*, 15 F.3d 1302 (5th Cir.), *reh'g denied*, 20 F.3d 471 (5th Cir. 1994), for example, the plaintiff argued that an administrator's conflict of interest warranted a lessened standard of review. Based on this Court's holding in *Firestone*, however, the Fifth Circuit disagreed:

> We fail to find Duhon's argument . . . fully convincing. . . . Although we agree that [there is a] possibility of a conflict of interest, we will follow the Supreme Court's direction in *Bruch* and weigh this possible conflict as a factor in our determination of whether the plan administrator abused his discretion, instead of adopting *ex cathedra* Duhon's suggestion of altering the applicable standard of review. Thus, the standard of review we apply in our review of the plan administrator's decision is the arbitrary and capricious or abuse of discretion standard, with due consideration given to the fact that the plan administrator in this case . . . possibly operated under a conflict of interest.

Id. at 1306. *See also Chevron Chem. Co. v. Oil, Chem. & Atomic Workers Local Union 4-447*, 47 F.3d 139, 143-44 (5th Cir. 1995); *Izzarelli v. Rexene Prods. Co.*, 24 F.3d 1506, 1513-14 & 1513 n.13 (5th Cir. 1994).

Thus, the circuits have adopted at least three divergent approaches to reviewing a decision by a fiduciary who has discretion to determine eligibility for benefits but who has been found to have operated under a conflict of interest. The

Fourth and Seventh Circuits would shrink the zone of deference to "even zero." The Ninth and Eleventh Circuits would apply the functional equivalent of *de novo* review unless the administrator or fiduciary could show that its interpretation was not made to serve its conflicting interests. The Fifth Circuit, by contrast, would apply the standard set forth in *Firestone*.

Members of this Court have observed that the circuits disagree on how to apply *Firestone* in reviewing benefits determinations. *Pierre v. Connecticut General Life Ins. Co.*, 502 U.S. 973 (1991) (White, J., dissenting).

Related Circuit Splits

The circuits' disagreement on this issue highlights the general confusion over the appropriate standard of judicial review in ERISA cases. The circuits split on at least three related issues concerning the appropriate deference for reviewing benefits determinations under *Firestone*.

(1) ***The language required to grant discretionary authority and thereby trigger deferential review.*** *Compare Stoetzner v. United States Steel Corp.*, 897 F.2d 115, 119 (3d Cir. 1990) (discretion granted when the administrator's decisions "shall be final and conclusive") *and Davis v. Kentucky Fin. Cos. Retirement Plan*, 887 F.2d 689, 694 (6th Cir. 1989) (discretion granted when the administrator has "final, conclusive and binding" authority), *cert. denied*, 495 U.S. 905, *reh'g denied*, 496 U.S. 932 (1990) *with Petrilli v. Drechsel*, 910 F.2d 1441, 1447 (7th Cir. 1990) (no discretion where plan makes administrator's decision "final and binding") *and Baxter v. Lynn*, 886 F.2d 182, 188 (8th Cir. 1989) (no discretion where administrator has "final authority to determine all matters of eligibility for payment of claims").

(2) ***The standard of review governing an administrator's factual determinations.*** *Compare Pierre v. Connecticut General Life Ins. Co.*, 932 F.2d 1552 (5th Cir.) (deference accorded to administrator's factual determinations), *cert. denied*, 502 U.S. 973 (1991) *with Luby v. Teamsters Health, Welfare & Pension Trust Fund*, 944 F.2d 1176 (3d Cir. 1991) (administrator's factual determination subject to *de novo* review).

(3) ***The admissibility of evidence that was not presented to the plan administrator during the claims review procedure.*** *Compare Perry v. Simplicity Engineering*, 900 F.2d 963 (6th Cir. 1990) (district court may not consider additional evidence) *with Donatelli v. Home Ins. Co.*, 992 F.2d 763 (8th Cir. 1993) (district court may consider additional evidence) *and Quesinberry v. Life Ins. Co. of N. Am.*, 987 F.2d 1017, 1026-27 (4th Cir. 1993) (district court may sometimes consider additional evidence).

Summary

This Court has recently reaffirmed *Firestone* and its underpinnings in the common law of trusts, *see Mertens v. Hewitt Assocs.*, 113 S. Ct. 2063, 2068 (1993). Nevertheless, the circuits conflict on nearly every conceivable issue under *Firestone*. *See, e.g.*, Annotation, 128 A.L.R. Fed. 1 (1995) (noting that after *Firestone*, issues regarding judicial review of plan determinations "have become more problematic" and "the scope of the deferential standards that might apply have been much litigated").

That creates an intolerable situation for all parties involved in creating and operating ERISA plans, because the law in this area sorely lacks the uniformity and predictability that is vital to effective plan administration. All parties would benefit from this Court's resolution of the many circuit splits that have arisen.

Seven years have elapsed since *Firestone*. The issues raised by that decision have more than adequately percolated through the courts of appeals. This Court should now resolve the conflicts in the circuits by reviewing the decision below.

II.

THE DECISION BELOW TO APPLY THE COMMON LAW *CONTRA PROFERENTEM* DOCTRINE IGNORES *FIRESTONE* AND CONTINUES AN INTOLERABLE CONFLICT ON A MATTER OF NATIONAL IMPORTANCE

In *Firestone*, this Court explained that "settled principles in trust law" require the courts to "construe terms and trust agreements without deferring to either party's interpretation." 489 U.S. at 112.

By contrast, the Fourth Circuit, after finding the plan's exclusion ambiguous, upheld the district court because "ambiguous language must be construed against the drafter." (A8) The court's reliance on the common law *contra proferentem* doctrine highlights another intolerable conflict among the circuits.

This conflict arose in 1990. The Ninth Circuit held that *contra proferentem* applies to ERISA cases, *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 540 (9th Cir.), *cert. denied*, 498 U.S. 1013 (1990), *reh'g denied*, 498 U.S. 1074 (1991), while the Eighth Circuit held that the doctrine "does not regulate insurance and is preempted by ERISA," *Brewer*

v. Lincoln Nat'l Life Ins. Co., 921 F.2d 150, 153 (8th Cir. 1990), *cert. denied*, 501 U.S. 1238 (1991).[2]

Since then, the Second Circuit has adopted a mixed approach. On the one hand, the court has approved *contra proferentem* for *de novo* review of ERISA insurance plans. *Masella v. Blue Cross & Blue Shield of Connecticut, Inc.*, 936 F.2d 98, 106 (2d Cir. 1991). On the other hand, a court is "less inclined" to apply the doctrine where the fiduciary has discretion to interpret the plan. *O'Neil v. Retirement Plan for Salaried Employees of RKO General, Inc.*, 37 F.3d 55, 61 (2d Cir. 1994).

The conflict persists. *See, e.g., McGee v. Equicor-Equitable HCA Corp.*, 953 F.2d 1192, 1200 n.11 (10th Cir. 1992) (discussing *contra proferentem*'s applicability and noting that the "circuits are split on this issue"). *Compare Bernards v. United of Omaha Life Ins. Co.*, 987 F.2d 486, 488 n.1 (8th Cir. 1993) (noting that *contra proferentem* "has no place in the construction of an ERISA plan") *and Finley v. Special Agents Mut. Ben. Ass'n*, 957 F.2d 617, 619 (8th Cir. 1992) (same) *with Patterson v. Hughes Aircraft Co.*, 11

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[2] ERISA sweepingly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan," 29 U.S.C. § 1144(a), while saving a state law if it "regulates insurance," 29 U.S.C. § 1144(b)(2)(A).

The Ninth Circuit did not reach the preemption question because it would irrespectively apply *contra proferentem*. *See Kunin*, 910 F.2d at 540 n.8. For two reasons, however, the Eighth Circuit "expressly disagree[d]" with *Kunin* and reached the opposite result. *Brewer*, 921 F.2d at 154 n.2. First, the court held that ERISA preempts *contra proferentem* because the doctrine "does not regulate the insurance industry." *Id.* at 153. Second, *Firestone* indicates that "neither party's construction should be favored." *Id.* at 153-54 (citing *Firestone*, 489 U.S. at 114).

F.3d 948, 950 (9th Cir. 1993) (applying *contra proferentum*) *and Phillips v. Lincoln Nat'l Life Ins. Co.*, 978 F.2d 302, 312 (7th Cir. 1992) (applying the doctrine while recognizing the direct split in the circuits).

The Fourth Circuit's reliance on the common law *contra proferentem* doctrine, like the court's altered standard of review, ignores this Court's *Firestone* decision and continues a direct conflict in the circuits.

CONCLUSION

The decision below exacerbates at least two conflicts in the circuits over important issues of ERISA's application. This Court's review is essential to establishing intelligible standards for judicial review of ERISA plan determinations. These standards are now in disarray.

By granting certiorari, this Court could resolve the conflict between *Firestone*, the ruling below, and decisions in other circuits. The Court could thus clarify the law governing judicial review of ERISA plans.

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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January 8, 1996

APPENDIX

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 94-2531

Argued July 12, 1995
Filed October 11, 1995

MARY BAILEY,

Plaintiff-Appellee,

v.

BLUE CROSS & BLUE SHIELD OF VIRGINIA,

Defendant-Appellant.

Before ERVIN, Chief Judge, MURNAGHAN, Circuit Judge, and BUTZNER, Senior Circuit Judge.

ERVIN, Chief Judge:

Insurer Blue Cross/Blue Shield of Virginia ("Blue Cross") challenges the district court's grant of summary judgment in favor of one of its policyholders, Mary Bailey. Bailey, who has breast cancer, seeks coverage for high dose chemotherapy that she claims is necessary to treat her condition. Blue Cross contends that it has no obligation to pay for the procedure, because it is excluded under Bailey's policy. We find that Bailey is entitled to coverage as a matter of law and, therefore, affirm the district court's grant of summary judgment.

I.

Mary Bailey, who suffers from stage IV breast cancer, has health insurance with Blue Cross through her husband's company, Bailey Enterprises. In June 1994, Bailey sought coverage for a procedure to treat her breast cancer known as

high dose chemotherapy with peripheral stem cell rescue ("HDC/PSCR"), which her doctor recommended as offering her the best chance for survival.* In summary, high doses of chemotherapy are considered more effective in killing cancer cells, and thus can be used to treat breast cancer. Unfortunately, in addition to killing malignant cells, the treatment also kills healthy white blood cells in the patient's blood stream and bone marrow, leaving her susceptible to deadly infections. To combat this problem, doctors have developed procedures in which a patient's "peripheral stem cells" are harvested prior to the administration of high dose chemotherapy or radiation. After the body is flooded with cancer-killing agents, the healthy cells are reinfused into the body to protect the patient against disease.

Blue Cross denied Bailey's request to fund the treatment described above, claiming that her policy excluded it. The insurer based its denial on an amendment to Bailey's policy that stated: "Autologous bone marrow transplants or other forms of stem cell rescue (in which the patient is the donor) with high dose chemotherapy or radiation are not covered." *Joint Appendix* at 180. Thereafter, the policy lists several exceptions, immediately followed by the disclaimer: "Autologous bone marrow transplants or other forms of stem cell rescue (with high dose chemotherapy and/or radiation), for all other cases are not covered. These include but are not limited to the following: . . . Breast cancer . . . ." *Id.* at 181. Blue Cross also relied on section VI(B) of the policy, which declares: "[T]he extent to which a Covered Person is

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* We have described in detail the treatment sought by Bailey on other occasions. For further discussion of the technical aspects of this treatment, *see Wheeler v. Dynamic Engineering, Inc.*, 62 F.3d 634 (4th Cir. 1995); *cf. Hendricks v. Central Reserve Life Ins. Co.*, 39 F.3d 507, 510 (4th Cir. 1994).

entitled to benefits under the Policy shall be determined by the Company in its sole discretion." Id. at 294.

Conceding that the policy provisions above exclude the peripheral stem cell rescue ("PSCR") portion of her treatment, Bailey contends that high dose chemotherapy is included, since chemotherapy is listed under the policy's definition of covered therapy services:

> These are the following services or supplies ordered by a provider used to treat or promote recovery from an illness or injury . . . (2) chemotherapy. the treatment of malignant disease by chemical or biological neoplastic agents. Oral chemotherapy is covered only if a drug used requires a physician's written prescription to obtain.

Id. at 158; *see also id.* at 164-66 (stating that the referenced "outpatient therapy services" are covered).

On September 13, 1994, Bailey filed suit in the United States District Court for the Eastern District of Virginia. On September 28, the district court granted Bailey's motion for a preliminary injunction prohibiting Blue Cross from denying payment for the treatment she had requested. *Id.* at 328-42. The parties then filed cross-motions for summary judgment. On October 31, the district court granted Bailey's motion and denied that of Blue Cross. The court found that the policy was ambiguous as it related to coverage for high dose chemotherapy:

> Defendants did not clearly exclude the HDC which if [sic] finds was specifically provided for elsewhere in the Policy, and as such the ambiguous clause is construed against the insurer. The Court makes this finding in light of the deference to be accorded to the administrator of the Policy under the facts of this case.

Id. at 373.

Blue Cross filed timely notice of appeal to this court. As this is an action under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq.*, the district court possessed subject matter jurisdiction pursuant to 29 U.S.C. § 1132. Appellate jurisdiction is proper under the authority of 28 U.S.C. § 1291.

II.

A.

We review *de novo* the district court's grant of summary judgment. *Ramos v. Southern Md. Elec. Coop.*, 996 F.2d 52, 53 (4th Cir. 1993). In a contractual matter such as this, "[w]here a case turns simply upon a reading of the document itself, there is no reason to believe that a district court is in any better position to decide the issue than is an appellate court," and we therefore exercise plenary review over the lower court's interpretation of the contract. *Hendricks*, 39 F.3d at 512. Under Rule 56(c) of the Federal Rules of Civil Procedure, summary judgment is appropriate if "there is no genuine issue as to any material fact and . . . the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c); *see Miller v. Federal Deposit Ins. Corp.*, 906 F.2d 972, 974 (4th Cir. 1990). In making this determination, we must view the evidence in the light most favorable to the non-moving party, granting that party the benefit of all reasonable inferences. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587, 106 S. Ct. 1348, 1356, 89 L. Ed. 2d 538 (1986); *Conkwright v. Westinghouse Elec. Corp.*, 933 F.2d 231, 233 (4th Cir. 1991). "If, however, 'the evidence is so one-sided that one party must prevail as a matter of law,' we must affirm the grant of summary judgment in that party's favor." *O'Connor v. Consolidated Coin Caterers Corp.*, 56 F.3d 542, 545 (4th Cir. 1995) (quoting *Anderson v. Liberty Lobby*, Inc., 477

U.S. 242, 251-52, 106 S. Ct. 2505, 2511-12, 91 L. Ed. 2d 202 (1986)).

Apart from the standards we use to evaluate the district court's rulings, we must also address the appropriate measure with which to review Blue Cross's denial of benefits under the ERISA plan it administers. *See Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 108-115, 109 S. Ct. 948, 953-57, 103 L. Ed. 2d 80 (1989). As noted above, that policy permits Blue Cross to determine the extent to which an insured is entitled to benefits "in its sole discretion." *Joint Appendix* at 294. Bailey argues that this language does not vest Blue Cross with discretionary authority, and that review is therefore *de novo*. Rather than vesting discretion in the plan administrator, Bailey contends that the provision at most "empowers some employee of Blue Cross to review claims to determine the *amount* or *extent* of coverage which exists for a particular claim." *Brief of Appellee* at 8. Based on the policy's plain language, we reject Bailey's interpretation that Blue Cross does not have the discretionary authority to qualify as a fiduciary under ERISA. *See* 29 U.S.C. § 1002(21)(A).

That Blue Cross has discretionary authority as plan administrator does not end our inquiry, however.

> [W]hen a fiduciary exercises discretion in interpreting a disputed term of the contract where one interpretation will further the financial interests of the fiduciary, we will not act as deferentially as would otherwise be appropriate. Rather, we will review the merits of the interpretation to determine whether it is consistent with an exercise of discretion by a fiduciary acting free of the interests that conflict with those of the beneficiaries. In short, the fiduciary decision will be entitled to some deference, but this deference will be lessened to the degree necessary to

> neutralize any untoward influence resulting from the conflict.

Doe v. Group Hospitalization & Medical Services, 3 F.3d 80, 87 (4th Cir. 1993). Blue Cross concedes that it operated under a conflict of interest when it denied the benefits sought by Bailey. It argues, though, that the district court erred by not articulating the degree of (lessened) deference it accorded Blue Cross's decision. Although the district court did not elaborate specifically on the degree of deference it considered appropriate, the lower court correctly articulated the legal standard we established in *Doe*. *Joint Appendix* at 364. Furthermore, after citing the relevant case law, it expressly found that Bailey was entitled to summary judgment "in light of the deference to be accorded to the administrator of the Policy under the facts of this case." *Id.* at 373. Although a more extensive analysis might have been helpful, we cannot say that the district court erred in its application of the law. A more thorough explanation might have been necessary had the conflict of interest not been as total as that in this case, where Blue Cross stood as the single beneficiary of a substantial sum based on its denial of benefits. *Cf. Brown v. Blue Cross and Blue Shield*, 898 F.2d 1556, 1564 (11th Cir. 1990) ("When the members of a tribunal—for example, the trustees of a pension fund—have a serious conflict of interest, the proper deference to give may be slight, even zero; the decision if wrong may be unreasonable.").

B.

Blue Cross next argues that even under the less deferential standard described above, its decision to deny Bailey benefits was proper, because the policy's language unambiguously indicates that high dose chemotherapy is not covered. Construing the exclusion for "stem cell rescue (in which the patient is the donor) with high dose chemotherapy or

radiation," Blue Cross essentially interprets "with" as unambiguously meaning "and." *Joint Appendix* at 180. In contrast, Bailey contends that the language is ambiguous as a matter of law. In assessing this argument, we must interpret the policy using ordinary principles of contract law, enforcing the plan's plain language in its ordinary sense. *Hardester v. Lincoln Nat. Life Ins. Co.*, 33 F.3d 330, 338 (4th Cir. 1994) (Hall, J., dissenting), *vacated on reh'g*, 52 F.3d 70 (4th Cir. 1995) (en banc) (adopting panel dissenting opinion). "Where a term is ambiguous, we must construe it against the drafter, and in accordance with the reasonable expectations of the insured." *Wheeler*, 62 F.3d at 638 (citations omitted).

Both parties rely on our holdings in *Doe*, 3 F.3d at 80, and *Hendricks v. Central Reserve Life Ins. Co.*, 39 F.3d 507 (4th Cir. 1994), as supporting their respective positions regarding whether the language at issue is ambiguous. In *Doe*, the "rescue" procedure preceding chemotherapy and radiation involved an autologous transplant of bone marrow, rather than peripheral stem cells. 3 F.3d at 82. The medical principles, however, were equivalent to those underlying the procedure for which Bailey seeks coverage. The insurance policy at issue in *Doe* excluded "services or supplies for or related to" the bone marrow transplant. *Id.* at 88. Elsewhere in the policy, coverage for chemotherapy and radiation specifically was provided. *Id.* at 87-88. Applying the less deferential abuse of discretion standard discussed above, we held that the policy covered the high dose chemotherapy portion of a cancer patient's treatment, *id.* at 89.

In contrast, we held in *Hendricks* that the plaintiff's insurance policy did not cover high dose chemotherapy. The policy at issue in that case excluded "treatment or services experimental or investigational in nature." 39 F.3d at 511.

After ruling that the desired HDC/PSCR treatment fell within the exclusion, the court rejected the plaintiff's argument that phases of the treatment other than the high dose chemotherapy itself were covered. "[T]o fragment the phases of treatment and consider each in light of the policy language produces an unrealistic and distorted analysis." *Id.* at 514.

Applying these cases, the ambiguity in Bailey's policy becomes apparent. The desire in *Hendricks* to avoid excessive fragmentation supports Blue Cross's view that HDC/PSCR is a unified treatment. On the other hand, if high dose chemotherapy was not a service "related to" the autologous bone marrow transplant in *Doe*, it is reasonable to conclude that the policy exclusion covers only the distinct PSCR. Moreover, as the district court found, "[t]he record does not preclude the possibility that there may indeed be cases where HDC is not accompanied by PSCR." *Joint Appendix* at 371. That possibility is consistent with Bailey's interpretation of the policy as providing coverage for all types of chemotherapy—including treatment with high doses.

We have held repeatedly that ambiguous language must be construed against the drafter. *Doe*, 3 F.3d at 89; *Glocker v. W.R. Grace & Co.*, 974 F.2d 540, 544 (4th Cir. 1992). Particularly because "Blue Cross' discretionary interpretation to the contrary is not entitled to the deference we might otherwise accord," *Doe*, 3 F.3d at 87, the district court's ruling prohibiting Blue Cross from denying coverage for Bailey's high dose chemotherapy was proper as a matter of law.

C.

Finally, Blue Cross contends that even if the policy language is ambiguous, the district court erred by granting summary judgment, because Bailey failed to present extrinsic

evidence as to meaning of the disputed terms. In *Goodman v. Resolution Trust Corp.*, 7 F.3d 1123 (4th Cir. 1993), we noted, however, that:

> A court faces a conceptually difficult task in deciding whether to grant summary judgment on a matter of contract interpretation. Only an unambiguous writing justifies summary judgment without resort to extrinsic evidence, and no writing is unambiguous if "susceptible to two reasonable interpretations." . . . If a court properly determines that the contract is unambiguous on the dispositive issue, it may then properly interpret the contract as a matter of law and grant summary judgment because no interpretive facts are in genuine issue. *Even where a court, however, determines as a matter of law that the contract is ambiguous, it may examine evidence extrinsic to the contract that is included in the summary judgment materials, and, if the evidence is, as a matter of law, dispositive of the interpretative issue, grant summary judgment on that basis.*

Id. at 1126 (quoting *World-Wide Rights Ltd. Partnership v. Combe Inc.*, 955 F.2d 242, 245 (4th Cir. 1992)) (emphasis added and internal citations omitted). Thus, while summary judgment typically is improper when a contract's language is ambiguous, it is appropriate where the evidence indicates that the moving party is entitled to judgment as a matter of law.

In this case, Blue Cross and Bailey filed cross-motions for summary judgment, demonstrating that each believed there were no disputed, material issues of fact. If the parties had negotiated regarding the policy's terms, extrinsic evidence concerning their intent might have been revealing. Here, though, we are presented only with boilerplate language that has replaced any negotiation process. "Where a case turns simply upon a reading of the document itself," *Hendricks*, 39

F.3d at 512, summary judgment may be available despite a contract's ambiguity. Based on its plain language, coverage for high-dose chemotherapy under Bailey's policy is ambiguous as a matter of law. Because such provisions are construed against the drafter, *Doe*, 3 F.3d at 89, summary judgment was proper.

III.

Accordingly, the judgment of the district court granting summary judgment in favor of Bailey is

AFFIRMED.

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
NORFOLK DIVISION

No. 2:94cv897

MARY BAILEY,

Plaintiff,

v.

BLUE CROSS/BLUE SHIELD OF VIRGINIA,

Defendant.

Filed September 30, 1994

ORDER

CLARKE, District Judge:

In this case, Plaintiff seeks a preliminary injunction pursuant to Rule 65 of the Federal Rules of Civil Procedure enjoining Blue Cross/Blue Shield of Virginia ("Blue Cross") from denying Plaintiff payment for certain medical procedures. For the following reasons, Plaintiff's motion is GRANTED.

FACTS

Mary Bailey, Plaintiff, was diagnosed with breast cancer in 1990. In 1994, Plaintiff's cancer metastasized so as to become stage IV breast cancer. The Plaintiff's treating physician, Dr. Thomas Alberico, a practicing oncologist, recommended to the Plaintiff that her best chance for living was to receive high-dose chemotherapy ("HDC") with peripheral stem cell rescue ("PSCR").

HDC/PSCR as it is to be administered to Plaintiff includes several stages. The first stage consists of the administration

of low does of chemotherapeutic agents, and Plaintiff has already undergone this stage. During the second stage, Plaintiff will be administered moderate doses of chemotherapeutic agents. During this phase of treatment, Plaintiff's body will produce extra amounts of components of the blood known as stem cells, and immediately subsequent to this stage, Plaintiff will have the stem cells removed by a procedure known as leukapheresis. The stem cells will be quickly frozen and stored in liquid nitrogen.

Subsequent to the leukapheresis stage, Plaintiff will receive high doses of standard chemotherapeutic agents, Plaintiff's cancer cells should have been killed along with health white blood stem cells. After the infusion of the above chemotherapy, Plaintiff will have her previously collected stem cells reinfused into her system so that her body will begin to rebuild the depleted stem cell count. Subsequent to re-administration of the stem cells, Plaintiff likely will be hospitalized for a short period for observation.

Plaintiff has been undergoing the standard chemotherapy, a necessary prelude to high-dose chemotherapy, and on September 26, 1994 Plaintiff began the HDC/PSCR treatment. The Plaintiff's husband is an employee of Bailey Enterprises and the Plaintiff has insurance with Defendant through Bailey Enterprises.

Plaintiff states in her affidavit that she understood that the treatment would cost between $80,000 and $150,000. Her husband, Byron Bailey, testified that Response Technologies, the provider of the treatment, later informed him that the cost of treatment will be between $90,000 and $100,000. To date, Plaintiff has incurred $21,0000 of bills for her chemotherapy. Although the Plaintiff's husband does have sufficient funds to pay for the treatment, in doing so he will jeopardize his business.

On June 23, 1994, Response Technologies wrote Defendant on behalf of Mrs. Bailey and sought coverage for high dose chemotherapy with peripheral stem cell support. Defendant denied the request stating that proposed procedure was not covered under the contract.

Plaintiff began her chemotherapy treatment in May 1994. Despite the denial letter, received June 1994, Plaintiff continues to seek medical treatment. This treatment includes high dose chemotherapy, radiation, and peripheral stem cell rescue. Plaintiff has now filed a Motion for a Preliminary Injunction and seeks to enjoin Defendant from denying coverage for the high dose chemotherapy and radiation treatment. Plaintiff is not seeking coverage for the peripheral stem cell rescue, the procedure which provides support for a patient receiving high does [sic] chemotherapy.

On September 28, 1994 the Court heard argument on the Plaintiff's Motion for Preliminary Injunction. The issue has been thoroughly briefed and supporting documents and affidavits from sworn testimony have been received. The issue on the preliminary injunction is now ripe for decision.

ANALYSIS

I. The *Blackwelder* Standard

In *Blackwelder Furniture Co. v. Selig*, the Fourth Circuit Court of Appeals, set forth a very clear path in considering a motion for preliminary injunctive relief. *Blackwelder*, 550 F.2d 189 (4th Cir. 1977). It established the following four factor test:

1) the likelihood of irreparable harm to the Plaintiff if the preliminary injunction is not granted;

2) the likelihood of harm to the Defendant if the preliminary injunction is granted;

3) the likelihood that the Plaintiff will succeed on the merits; and

4) the public interest.

Id. at 195-96.

However, these factors are not weighted equally: the "balance of hardships" inquiry is the most important determination. *Id.* Therefore, if the harm to the Plaintiff by failing to grant the injunction would outweigh the harm to the Defendant in issuing the injunction, the Plaintiff's burden of proving success on the merits is diminished. Accordingly, if the Plaintiff meets this threshold inquiry, then it will be sufficient that she raises questions going to the merits which are "so serious, substantial, difficult and doubtful as to make them fair ground for litigation and thus for more deliberate investigation." *Id.* at 195 (quoting *Hamilton Watch Co. v. Benrus Watch Co.*, 206 F.2d 738, 740, 743 (2d Cir. 1953). "The decision to grant or deny a preliminary injunction depends upon a flexible interplay among all the factors considered. . . . for all four are intertwined and each affects in degree all the others." *Id.* at 196.

The standard of review the Court will use in a hearing on the merits is governed by the Employee Retirement Income Security Act ("ERISA"). 29 U.S.C. § 1001 et seq. (1985 & Supp. 1994). Court actions challenging the denial of benefits under 29 U.S.C. § 1132(a)(1)(B) are subject to the standard for review announced in *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 109 S. Ct. 948 (1989). *Firestone* held that in reviewing actions of a fiduciary who has been given discretionary powers to determine eligibility for benefits and to construe the language of an ERISA plan deference must be shown, and the fiduciary's actions will be reviewed only for abuse. *Id.* at 956. However, the Court went on to recognize that a conflict of interest could lower the level of deference

to be applied to a discretionary decision by a fiduciary. "[I]f a benefit plan gives discretion to an administrator. . . . who is operating under a conflict of interest, that conflict must be weighted as a 'factor in determining whether there is an abuser of discretion.'" *Id.* at 957 (quoting Restatement (Second) of Trusts § 187 comment d (1959)).

Furthermore, the Fourth Circuit Court of Appeals held:

> [W]hen a fiduciary exercises discretion in interpreting a disputed term of the contract where one interpretation will further the financial interests of the fiduciary, we will not act as deferentially as would otherwise be appropriate. Rather, we will review the merits of the interpretation to determine whether it is consistent with an exercise of discretion by a fiduciary acting free of the interests that conflict with those of the beneficiaries.

Doe v. Group Hospitalization & Medical Services, 3 F.3d 80, 87 (4th Cir. 1993). Defendant has conceded that this lower standard applies. In order to grant the Motion for Preliminary Injunction, the Court must find that the Plaintiff, taking in consideration the lower level of deference and weight to be given to the decision by the Blue Cross Administrator, must have raised questions going to the merits which are "so serious, substantial, difficult and doubtful as to make them fair grounds for litigation and thus for more deliberate investigation." *Blackwelder*, 550 F.2d at 195.

A. Balance of Harms

The Court finds that balance of the hardship analysis favors the Plaintiff. The Plaintiff is suffering from stage IV breast cancer, a life threatening disease. Her private practitioner, Dr. Thomas Alberico, stated that the Plaintiff's best chance for living is to receive high dose chemotherapy with the peripheral stem cell rescue support procedure. Defendant argues that a preliminary injunction is

extraordinary relief and need not be granted in this case because Plaintiff plans to go forward with the treatment regardless of whether this injunction is issued. However, the Court finds that the harm to the plaintiff through her husband if the injunction is not issued is materially greater than the harm to the Defendant by issuing an injunction.

Plaintiff's husband, Byron Bailey testified at the hearing as to his assets and liabilities. Mr. Bailey conveyed to the Court what financial arrangement he has been able to make thus far in order to assure that his wife was receiving the necessary medical treatment. While it is indeed true that Mr. Bailey made it quite clear that he would continue to pay for the necessary treatment regardless of the outcome of this injunction, such devotion does not come without irreparable harm to Plaintiff and her husband. Mr. Bailey's testimony emphasized his short term ability to pay the price of his wife's medical treatment. Mr. Bailey testified that in order to keep his business from going bankrupt he must have $50,000 in liquid assets available; otherwise, his various lenders will call in his loans for lack of collateral. If the various lenders were to call in his loans, it would force him to go out of business. Therefore, recognizing the material harm faced by the Plaintiff, and contrasting that with the relatively minor harm to Blue Cross, the largest heath insurer in the state, this Court moves to the second *Blackwelder* factor.

B. Likelihood of Success on the Merits

Defendant argues that the Plaintiff is not likely to succeed on the merits and therefore a preliminary injunction should not issue. As pointed out above, because the harm to the Plaintiff by failing to grant the injunction would outweigh the harm to the Defendant in issuing the injunction, the Plaintiff's burden of proving success on the merits is

diminished. *Blackwelder*, 550 F.2d at 196. All of the factors are to be considered together and "each affects in degree all the others." *Id.* Plaintiff has demonstrated that the harm to her if the injunction is denied outweighs the harm to Defendant if such an injunction issues; therefore, Plaintiff's burden to show the likelihood of success on the merits is somewhat diminished.

1. Amount of Deference

In a hearing on the merits, as enunciated above, the ordinary standard of review, which grants deference to the fiduciary, is diminished when a conflict of interest exists, and less deference is given to the fiduciary's decision. *See Doe*, 3 F.3d at 87. In the instant case, such a conflict of interest does exist. As stated in the Blue Cross Comprehensive Group Policy, "[t]he extent to which a Covered Person is entitled to benefits under the Policy shall be determined by the Company in its sole discretion." Def. Mem. Opp. Pl's. Mot. Prelim. Inj., Encls. 1 at 23. Defendant concedes that a conflict of interest exists. In fact, in both Defendant's brief and oral argument Defendant did not argue that the lower standard was not applicable; rather, Defendant stated there was no real need to grant deference to Defendant's decision because the Policy contains unambiguous language excluding the coverage for Mrs. Bailey's treatment.

2. Is it Likely that an Ambiguity Exists?

In determining if it is likely that Plaintiff demonstrate that an ambiguity exists, it is necessary to turn to the plain language in the Policy.

First, the policy specifically provides that chemotherapy treatment is a "therapy service", and page 15 of the policy states:

> Therapy services which are rendered to an outpatient by a covered facility or provider are covered. Any one of the following therapy services prescribed by a provider licensed to do so may be furnished and billed whereby a therapist appropriately licensed, certified or otherwise qualified (as determined by the Company), to render such services.

There is little doubt that the outpatient chemotherapy Plaintiff will receive is specifically covered under the Policy as a therapy service. In fact, this point was not contested by Defendant. The real issue is whether the treatment is excluded. The policy has exclusions as follows:

> EXCLUSIONS:
>
> The following is a list of services which will not, under any circumstances, be covered.
>
> . . .
>
> AMENDMENT
>
> (2) Autologous bone marrow transplants or other forms of stem cell rescue (in which the patient is the donor) with high dose chemotherapy and/or radiation are not covered.
>
> The following are exceptions: (Several types of cancer are listed in this section, none of them being the Plaintiff's cancer.) Autologous bone marrow transplants and other forms of stem cell rescue (in which the patient is the donor) with high dose chemotherapy and/or radiation for all other cases are not covered.
>
> These include but are not limited to the following . . . breast cancer.

The above exclusion undoubtedly, specifically, excludes the stem cell rescue. The question is, is the above exclusion intended to exclude the HDC treatment administered during the same overall treatment plan as the stem cell rescue. Plaintiff submits, and this Court agrees, that it has raised substantial doubts that the HDC itself is clearly excluded.

The clause could be interpreted in more than one way. It could be interpreted to mean that the stem cell rescue and all HDC administered during the same treatment plan are excluded. The clause could also be interpreted to mean that stem cell rescue only when administered with HDC is excluded. This interpretation would not include HDC, which is specifically covered under the policy, as part of the exclusion The latter interpretation is possible because the clause uses the ambiguous term "with".

Pursuant to the Doe case, ambiguous terms in an insurance policy are to be construed in favor of coverage and against the insurance company when the discretionary interpretation to the contrary is not entitled to the deference that might otherwise apply. *See Doe*, 3 F.3d at 89. Furthermore, *Doe* stated, "[an] exclusion should not, in the absence of clear language, be construed to withdraw coverage explicitly granted elsewhere in the contract." *Id.* at 88. In the instant case, the Policy does explicitly provide for chemotherapy under its "therapy services" and the plaintiff has raised a serious question as to whether the exclusion clearly includes the HDC.

In arguing that there is nothing even remotely ambiguous about the exclusion, Defendant set forth several arguments. First, Defendant alleged that Plaintiff's counsel had already conceded as much and that this Court in *Wheeler v. Dynamics Engineering & CHAMPUS*, 850 F. Supp. 45> (E.D. Va. 1994), had ruled as much. The Court finds that

Defendant has misread the holding in *Wheeler*. Defendant construes *Wheeler* to find that the amendment, "specifically excludes coverage of HDC/PSCR for the treatment of breast cancer." *Id.* at 463. Further, Defendant cites to *Wheeler* as stating, "the parties are in agreement that if [the contract amendment] controls the Plaintiff's treatment is excluded." *Id.* at 464. While it is indeed true that these quotas found in *Wheeler*, the Court finds that Defendant did not read them in context. The Court finds several key sentences in the Court's holding that clearly indicate that the issue before the Court in the instant case was not at issue in the *Wheeler* case. *Wheeler* stated, "[i]n the present case, however, the parties are not contesting the terms of the Blue Cross plan coverage." *Id.* at 464. "Because the Court's analysis *will not be called on to construe the terms of a health plan but will instead determine which plan applies. . . .*" *Id.* (emphasis added). It is clear to this Court that the Court in *Wheeler* chose not to consider the terms of the contract as an issue and as such this Court did not rule on or construe the terms of the health plan.

Second, Defendant argues that it has faced litigation throughout the country over coverage for high dose chemotherapy with various forms of rescue, and that the courts themselves have invited clarification of coverage in contracts and the wording in the contract at issue is that clarification. Defendant then quotes one of the suggested clarifications: "it would have been simple to provide a statement in the contract such as 'High dose chemotherapy with bone marrow transplant is not covered.'" *Nesseim v. Mail Handlers Benefit Plan*, 792 F. Supp. 674, 678 (D.S.D. 1992). Defendant then points out that Blue Cross did "precisely as the courts suggested—adding a specific exclusion in its contracts so there could be no confusion about coverage." Def. Memo. Opp. Pl.'s Mot. Prelim. Inj.

at 8. Defendant then relies on the following exclusion from its contract at issue in this case,

> autologous bone marrow transplants or other forms of stem cell rescue (in which the patient is the donor) with high does chemotherapy or radiation.

The Court finds such a plea unconvincing. First, the Court notes that the language used in the Policy at issue in this case is not the same as the language suggested by the Court in *Nesseim*. The Policy at issue in this case did add a specific exclusion as to the stem cell rescue, but what is at issue in this case is whether the HDC is specifically included as part of that exclusion. The Court finds that Plaintiff's have established a serious doubt whether the Policy in this case is clear with regard to the HDC.

Finally, Defendant argues that the Plaintiff can not succeed on the merits in establishing that the contract was ambiguous because Defendant offered a rider that would have explicitly provided for stem cell rescue. Defendant conceded that it was not sure whether Mrs. Bailey would have qualified for the rider because a condition in the rider required that the insured not have any known conditions. Plaintiff demonstrated she would not have been eligible because of her pre-existing condition. Plaintiff was diagnosed with breast cancer in 1990 and the rider was first available in 1992.

Defendant argues that it is irrelevant whether Plaintiff would have been eligible and that the rider only demonstrates that the Policy exclusion intended to also exclude the HDC treatment. The Court finds this argument unpersuasive. First, the language is identical to that language in the Policy at issue. As such, it is clear that the rider is a way to provide for treatment of stem cell rescue, but it is still ambiguous whether the rider applies to HDC. Second, the

rider does not answer the question at issue in this case: Does the Policy clearly and unambiguously exclude HDC?

The Court concludes that Plaintiff has met her burden and has raised questions going to the merits which call for more deliberate investigation.

C. Public Interest

The final factor in the *Blackwelder* standard is determining wherein lies the public interest. *Blackwelder*, 550 F.2d at 193 (citing *Airport Comm. of Forsyth Co., N.C. v. CAB*, 296 F.2d 95 (4th Cir. 1961). Defendant argues that it is in the public interest to have contracts honored as they are written. The Court agrees with this and in so doing finds that the public interest sides with the Plaintiff in the instant case. The public has an interest in receiving health care when it is in a contract and has been paid for. Furthermore, it is in the public interest for insurance companies to provide for the necessary exclusions in clear and unmistakable language. This Court finds that the public interest favors Plaintiff in this case.

II. The Bond Requirement

Rule 65(c) provides that "no . . . preliminary injunction shall issue except upon the giving of a security by the applicant, in such sum as the court deems proper, for the payment of such costs and damages as may be incurred or suffered by any party who is found to have been wrongfully enjoined or restrained." Fed. R. Civ. P. 65(c). While the decision whether to require a bond is strictly circumscribed by Rule 65(c), the computation of the bond amount is soundly within the Court's discretion. *Id.*; *see also Maryland Dep't of Human Resources v. United States Dep't of Agriculture*, 976 F.2d 1462, 1483 (4th Cir. 1992).

The Court finds that Plaintiff has adequate resources to post a bond. The Court orders a Plaintiff to post bond in the amount of $50,000 which may be secured by a lien on this home.

CONCLUSION

Therefore, under the analysis set forth in *Blackwelder*, this Court finds that the Plaintiff has demonstrated that the balance of the harms favors her position and Plaintiff has raised serious questions involving the merits of the case. Accordingly, it is hereby ORDERED that Blue Cross is preliminarily enjoined from denying payment to Mary Bailey for high-dose chemotherapy and radiation treatment until a hearing is conducted on the merits of this case and the issues which have been presented are decided. The Court notes that this matter has been set for hearing on October 24, 1994 at which time the Court will consider any new evidence and argument presented by either party.

The Clerk is directed to mail a copy of this Order to all counsel of record.

It is so ORDERED.

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
NORFOLK DIVISION

No. 2:94cv897

MARY BAILEY,

Plaintiff,

v.

BLUE CROSS/BLUE SHIELD OF VIRGINIA,

Defendant.

Filed November 1, 1994

ORDER

CLARKE, District Judge:

This case is currently before the Court on cross-motions for summary judgment pursuant to Rule 56(c) of the Federal Rules of Civil Procedure. For the following reasons, Plaintiff's motion is GRANTED and Defendant's motion is DENIED. A Permanent Injunction is also issued against the Defendant enjoining it from denying coverage for high dose chemotherapy, radiation treatment and the hospitalization associated with such treatment.

FACTS

Mary Bailey, Plaintiff, was diagnosed with breast cancer in 1990. In 1994, Plaintiff's cancer metastasized so as to become stage IV breast cancer. The Plaintiff's treating physician, Dr. Thomas Alberico, a practicing oncologist, recommended to the Plaintiff that her best chance for living was to receive high-dose chemotherapy ("HDC") with peripheral stem cell rescue ("PSCR").

HDC/PSCR as it is to be administered to Plaintiff includes several stages. The first stage consists of the administration of low doses of chemotherapeutic agents, and Plaintiff has already undergone this stage. During the second stage, Plaintiff will be administered moderate doses of chemotherapeutic agents. During this phase of treatment, Plaintiff's body will produce extra amounts of components of the blood known as stem cells, and immediately subsequent to this stage, Plaintiff will have stem cells removed by a procedure known as leukapheresis. The stem cells will be quickly frozen and stored in liquid nitrogen.

Subsequent to the leukapheresis stage, Plaintiff will receive high doses of standard chemotherapeutic agents. Plaintiff's cancer cells should be killed along with healthy white blood stem cells by the treatment at this stage. After the infusion of the above chemotherapy, Plaintiff will have her previously collected stem cells reinfused into her system so that her body will begin to rebuild the depleted stem cell count. Subsequent to re-administration of the stem cells, Plaintiff likely will be hospitalized for a short period for observation. Plaintiff has undergone the standard chemotherapy, a necessary prelude to high-dose chemotherapy, and on September 26, 1994 Plaintiff began the HDC/PSCR treatment.

The Plaintiff's husband is an employee of Bailey Enterprises and the Plaintiff has insurance with Defendant through Bailey Enterprises. Plaintiff states in her affidavit that she understood that the treatment would cost between $80,000 and $150,000. Her husband, Byron Bailey, testified that Response Technologies, the provider of the treatment, later informed him that the cost of treatment will be between $90,000 and $100,000.

On June 23, 1994, Response Technologies wrote Defendant on behalf of Mrs. Bailey and sought coverage for high dose chemotherapy with peripheral stem cell support. On June 24, 1994, Defendant denied the request stating that proposed procedure was not covered under the contract.

Plaintiff began her chemotherapy treatment in May 1994. Despite the denial letter, received on June 24, 1994, Plaintiff continued to seek medical treatment. Plaintiff's treatment includes high dose chemotherapy, radiation, and peripheral stem cell rescue. On September 28, 1994, this Court issued a preliminary injunction, enjoining Defendant from denying coverage for the high dose chemotherapy and radiation treatment.[1] This case now comes before the Court on the parties' cross-motions for summary judgment.[2] By an agreement between the parties, the case was submitted on the briefs alone, without a trial, hearing or oral argument.

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[1] Plaintiff did not seek coverage for the peripheral stem cell rescue, the procedure which provides rupport for a patient receiving high dose chemotherapy. Plaintiff only sought coverage for the administration of the HDC and services specifically related to that treatment and for the subsequent hospitalization and services provided during the hospitalization.

[2] By agreement of the parties each side choose to submit a Motion for Summary Judgment and supporting Memoranda and neither party choose to file a responsive Memorandum. Furthermore, Plaintiff acknowledged that the Defendant included additional affidavits in support of summary judgment and still chooses not to respond; although, the Court does note that in Plaintiff's letter confirming the decision to not respond to the affidavits, Plaintiff did comment on the contents of the affidavit of Dr. J. Lawrence Colley.

ANALYSIS

I. Standard of Review & Procedural Posture

Rule 56 provides that:

> The judgment sought shall be rendered forthwith if the pleadings, depositions, answers to interrogatories and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law.

Fed. R. Civ. P. 56. A "motion for summary judgment may be granted if the question to be determined involves the construction of a written agreement which is set out in full in the complaint since the question is one of law." *Noel v. Baskin*, 131 F.2d 231 (D.C. Cir. 1942).

This case involves a question of contract interpretation. Before turning to the exclusion at issue, the Court must address the applicable standard of review. The standard of review the Court must use is governed by the Employee Retirement Income Security Act ("ERISA"). 29 U.S.C. § 1001 *et seq.* (1985 & Supp.1994). Court actions challenging the denial of benefits under 29 U.S.C. § 1132(a)(1)(B) are subject to the standard of review announced in *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989). *Firestone* held that in reviewing actions of a fiduciary who has been given discretionary powers to determine eligibility for benefits and to construe the language of an ERISA plan deference must be shown, and the fiduciary's actions will be

reviewed only for abuse.[3] *Id.* at 113, 109 S. Ct. at 956. However, the Court went on to recognize that a conflict of interest could lower the level of deference to be applied to a discretionary decision by a fiduciary. "[I]f a benefit plan gives discretion to an administrator . . . who is operating under a conflict of interest, that conflict must be weighed as a 'factor in determining whether there is an abuse of discretion.'" *Id.* at 115, 109 S. Ct. at 957 (quoting Restatement (Second) of Trusts § 187 comment d (1959)).

Furthermore, the Fourth Circuit Court of Appeals has held:

> [W]hen a fiduciary exercises discretion in interpreting a disputed term of the contract where one interpretation will further the financial interests of the fiduciary, we will not act as deferentially as would otherwise be appropriate. Rather, we will review the merits of the interpretation to determine whether it is consistent with an exercise of discretion by a fiduciary acting free of the interests that conflict with those of the beneficiaries.

Doe v. Group Hospitalization & Medical Services, 3 F.3d 80, 87 (4th Cir. 1993). More recently, the Western District of North Carolina has held that an ERISA health plan administrator's role as both the fiduciary of plan and an employee of the plan provider presented a conflict of interest warranting a less deferential review of administrator's decision to deny benefits than the abuse of discretion standard which otherwise would have applied. *Foster v. State Farm Mut. Auto. Ins. Co.*, 843 F. Supp. 89, 92

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[3] In the instant case, Defendant relies on the affidavit of Dr. J. Lawrence Colley, its Vice President in charge of the Corporate Medical Policy division, in support of its position that under the contract language HDC administered in conjunction with PSCR is clearly excluded.

(W.D.N.C. 1994). Foster held that the administrator had a conflict between his duty to minimize employer's costs and his fiduciary duties to those covered by plan. *Id.* As the Doe Court recognized, "Even the most careful and sensitive fiduciary in those circumstances may unconsciously favor its profit interest over the interest of the plan, leaving beneficiaries less protected than when the trustee acts without self-interest and solely for the benefit of the plan." *Doe*, 3 F.3d at 86, 87. In *Foster*, the Court held:

> the Court must determine if the administrator faithfully executed its duty to interpret the Plan "solely in the interests of the participants and beneficiaries . . . for the purpose of providing benefits [to them] . . . with the care, skill, prudence, and diligence under the circumstances prevailing that a prudent man acting in like capacity . . . would use . . ." despite the conflict.

Foster, 843 F. Supp. at 93. (quoting 29 U.S.C. § 1104(a)(1)(A, B)).

Defendant has conceded that this lower standard applies. The Comprehensive Group Policy ("Policy") in issue gives Blue Cross discretion in making coverage decisions.[4] Blue Cross clearly exercises discretionary authority or discretionary control with respect to the management of the plan and therefore qualifies as a fiduciary under ERISA. 29 U.S.C. § 1002(21)(A). *See Doe*, 3 F.3d at 87. With that lessened degree of deference to Blue Cross' discretionary interpretation of the group insurance contract, we turn to review Blue Cross' decision to deny benefits.

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[4] The Policy states, "[t]he extent to which a Covered Person is entitled to benefits under the Policy shall be determined by the Company in its sole discretion." Policy at 23.

II. The Contract

To determine whether the procedures for which coverage was claimed are covered by the Blue Cross contract, the Court must first consider the nature of the treatment for which benefits are sought.

As outlined above, Plaintiff has stage IV breast cancer. The Plaintiff is being treated by a procedure known as HDC/PSCR. As part of this treatment, Plaintiff will receive chemotherapeutic agents, approved by the Federal Drug Administration, in high doses. The high doses of the chemotherapy are intended to kill the cancerous cell polluting Plaintiff's body, but they also kill healthy white blood cells which make up the body's immune system. Without healthy white blood cells, an individual does not have a healthy immune system and without an immune system, an individual is susceptible to infection and death. To rebuild the body's immune system, healthy white blood cells are removed prior to the administration of the high dose chemotherapy and reinfused subsequent. After reinfusion of the healthy white blood cells, the white blood cells begin to reproduce themselves and the immune system, thereby preventing infection. The PSCR in no way directly treats the cancer, and it is only the chemotherapy treatment which is intended to kill the cancer.

It is undisputed that the Policy specifically provides that chemotherapy treatment is a "therapy service":

> Therapy services which are rendered to an outpatient by a covered facility or provider are covered. Any one of the following therapy services prescribed by a provider licensed to do so may be furnished and billed whereby a therapist appropriately licensed, certified or otherwise qualified (as determined by the Company), to render such services.

As defined in the Policy, "Therapy Services" includes radiation therapy and chemotherapy.[5] There is no doubt that the outpatient chemotherapy Plaintiff will receive is specifically covered under the Policy as a therapy service. In fact, this point was not contested by Defendant. The real issue is whether the treatment being rendered in this case is excluded. The policy has exclusions as follows:

> EXCLUSIONS:
>
> The following is a list of services which will not, under any circumstances, be covered.
>
> . . . . .
>
> AMENDMENT
>
> (2) Autologous bone marrow transplants or other forms of stem cell rescue (in which the patient is the donor) with high dose chemotherapy and/or radiation are not covered.
>
> The following are exceptions: (Several types of cancer are listed in this section, none of them being the Plaintiff's cancer.) Autologous bone marrow transplants and other forms of stem cell rescue (in which the patient is the donor) with high dose chemotherapy and/or radiation for all other cases are not covered.
>
> These include but are not limited to the following . . . breast cancer.

The above exclusion undoubtedly, specifically, excludes the peripheral stem cell rescue when accompanied by high dose chemotherapy. The question is, is the above exclusion intended to exclude the HDC treatment administered during the same overall treatment plan as the stem cell rescue.

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[5] Chemotherapy is defined as "the treatment of malignant disease by chemical or biological antineoplastic agents." Policy at 7.

A. Plaintiff's Argument

Plaintiff submits that the clause, "with high dose chemotherapy" could be interpreted in more than one way. First, it could be interpreted to mean that the stem cell rescue and all HDC administered during the same treatment plan are excluded. The clause could also be interpreted to mean that stem cell rescue only when administered with HDC is excluded. This interpretation would not include HDC, which is specifically covered under the policy, as part of the exclusion. The latter interpretation is possible because the clause uses the ambiguous term "with".

Pursuant to the *Doe* case, ambiguous terms in an insurance policy are to be construed in favor of coverage and against the insurance company when the discretionary interpretation to the contrary is not entitled to the deference that might otherwise apply. *See Doe*, 3 F.3d at 89. Furthermore, *Doe* stated, "[an] exclusion should not, in the absence of clear language, be construed to withdraw coverage explicitly granted elsewhere in the contract." *Id.* at 88.

In the instant case, the Policy does explicitly provide for chemotherapy under its "therapy services" and it is unclear whether the exclusion clearly includes the HDC. As set forth in the affidavit of Dr. Elizabeth Harden, all the phases and procedures involved in Plaintiff's treatment are somewhat interrelated in the sense that they are all administered as part of one treatment plan geared towards ultimately curing Plaintiff's condition, but the phases are separate and distinct phases of treatment. Furthermore, Dr. Harden states that the treatment which is intended to "cure" Plaintiff is the HDC aspect of the treatment; whereas the PSCR is but a support procedure and is a very minor portion of Mrs. Bailey's overall treatment plan.

B. Defendant's Argument

On the other hand, the Defendant argues that there is nothing even remotely ambiguous about the exclusion in the Policy. The Defendant sets forth several arguments. First, Defendant cites to *Brand Distribs., Inc. v. Insurance Co. of N. America*, as defining when a word is ambiguous:

> only when it is found to be of uncertain meaning by persons of competent skill and information; that is, when viewed objectively by a reasonably intelligent person who has examined the context of the entire integrated agreement and who is cognizant of customs, practices, usage and terminology as generally understood in the particular trade or business.

400 F. Supp. 1085, 1090 (E.D. Va. 1974), *rev'd on other grounds*, 532 F.2d 352 (4th Cir. 1976). The Defendant contends that when viewed objectively by a person who has an awareness of the customs, practices and terminology as generally understood in the particular trade, the Policy exclusion is not ambiguous. Yet, the Court notes that more recently, the Eastern District of Virginia has held that an insurance contract that supports two equally fair interpretations is ambiguous. *Atkinson Dredging Co. v. St. Paul Fire & Marine Ins. Co.*, 836 F. Supp. 341, 344 n.8 (E.D. Va. 1993).

Defendant asserts there is only one reasonable interpretation of the language. It is the Defendant's position that the only reasonable interpretation is that the clause "with high dose chemotherapy" describes the other important component of a single treatment plan which also involves autologous peripheral stem cell rescues, the entirety of which is excluded.

Blue Cross interprets the word "with" as synonymous with the word "and" and it views both the autologous peripheral stem cell rescue and the high dose chemotherapy as excluded. In choosing to view the words "with" and "and" as synonymous, Defendants rely on the "nature of the procedure" to reinforce this conclusion. Defendants then go on to state that since 1) Mrs. Bailey herself acknowledges that HDC/PSCR is a single procedure with a number of components; 2) Response Technologies described the plan as having a number of "components"; and 3) case law states that HDC/PSCR is one unified treatment plan, that "with" and "and" are synonymous. However, the Court finds such reasoning unpersuasive.

Also in support of their position that "with" and "and" are synonymous, Defendant relies on an affidavit attached to its Motion for Summary Judgment. Blue Cross filed the affidavit of Dr. J. Lawrence Colley, a Vice President of Blue Cross in charge of the Corporate Medical Policy division in which Dr. Colley states:

> autologous bone marrow transplants or other forms of autologous stem cell rescue are dealt with in Paragraph 2 of the Policy exclusion. These procedures would obviously be of no benefit by themselves. Instead, they are used only as a form of rescue following high dose chemotherapy or radiation.

Relying on this assertion, Dr. Colley goes on to conclude: "the word "with" is synonymous with the word "and" because autologous transplants or other forms of autologous stem cell rescue would never be used without high dose chemotherapy or radiation."

The Court finds the Defendant's position unpersuasive and concludes that the exclusion is indeed unclear and ambiguous. First, the Court notes that it is a question of law

for the Court to decide if the contract is ambiguous. *Atkinson Dredging Co.*, 836 F. Supp. at 345 n.11; *Nehi Bottling v. All-American Bottling*, 8 F.3d 157, 161 (4th Cir. 1993). The Court finds that the clause could be read as meaning that a peripheral stem cell rescue and all HDC administered during the same treatment plan are excluded; but at the same time, the Court also finds that the exclusion could be interpreted as meaning that the stem cell rescue, only when administered with the HDC, which is otherwise specifically covered under the policy, is excluded.

Defendant relies on the defense that HDC and PSCR are a "single procedure" and thus the "with" must be considered "and." The Court finds that the argument as set forth by the Defendant, including the affidavit of Dr. Colley is insufficient and unpersuasive. Both parties were given the opportunity to call witnesses and present additional evidence and both sides declined. The record does not preclude the possibility that there may indeed be cases where HDC is not accompanied by PSCR or ABMT. They certainly are different procedures in that they are administered at different times and for different purposes. The purpose of HDC is to kill the cancer; whereas, the purpose PSCR is to restore the immune system.

In *Doe*, the Fourth Circuit has recently found that a Blue Cross Policy exclusion at issue in that case was not explicit enough in excluding the HDC portion of the unified treatment plan. *Doe* stated, "[w]hile Blue Cross is well within its rights to exclude from coverage the ancillary bone marrow transplant procedure, the exclusion should not, in the absence of clear language, be construed to withdraw coverage explicitly granted elsewhere in the contract." *Doe*, 3 F.3d at 88. Defendants contend that in the current policy the HDC is specifically identified as part of the excluded procedure and therefore an ambiguity does not exist. In

Doe, the disputed clause, "services or supplies for or related to" was ambiguous. In *Doe*, Blue Cross argued that the language reached to exclude HDC and radiation treatment because without the ABMT, the HDC could not be performed. In rejecting this argument, the Fourth Circuit stated that "the first question to be asked, therefore, is whether the cancer treating procedure is covered by the contract." *Id.* As in *Doe*, the answer in the instant case is clearly yes.

The question then becomes whether Blue Cross clearly excluded the HDC. Plaintiff submits that the contract is ambiguous because, as noted above, more than one reasonable interpretation exists. Defendants concede that Plaintiff is theoretically correct that the Policy exclusion could be read in two way; however, Defendants assert that the second interpretation is not reasonable and therefore does not create an ambiguity.[6]

Defendant is relying on language in a section of the policy which covers exclusions. The section in question states that PSCR is not covered if the patient is also receiving HDC in the same procedure. The HDC is specifically included

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[6] Defendants support this position further by stating that this is especially true when Blue Cross is given the deference to which it is entitled in interpreting the Policy. However, as noted in Doe, the Court may take account of the principle that in making a reasonable decision, ambiguity which remains in the exclusion must be construed against the drafting party. *Doe*, 3 F.3d at 89. *See also Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 539 (9th Cir. 1990) (using a presumption such as construction against the drafter in evaluating the reasonableness of an interpretation is not inconsistent with review for abuse of discretion).

elsewhere in the Policy.[7] Several Courts have held that exceptions to the basic, underlying contract obligation must be stated clearly to apprise the insured of the effect of those exceptions. *See Sentinel Associates v. American Mfrs. Mut. Ins.*, 804 F. Supp. 815 (E.D. Va. 1992) (holding that "it is incumbent upon an insurer to employ exclusionary language that is clear and unambiguous. Language is ambiguous, under Virginia law, when it may be understood in more than one way."); *Interstate Fire & Cas. Co. v. Stuntman Inc.*, 861 F.2d 203, 204-05 (9th Cir. 1988); *Gray v. Zurich Ins. Co.*, 65 Cal. 2d 263, 54 Cal. Rptr. 104, 108, 419 P.2d 168, 172 (1966); [sic]

In applying this reasoning to the instant case, the Court finds that the Defendants did not clearly exclude the HDC which if finds was specifically provided for elsewhere in the Policy, and as such the ambiguous clause is construed against the insurer. The Court makes this finding in light of the deference to be accorded to the administrator of the Policy under the facts of this case.

CONCLUSION

For the foregoing reasons, Summary Judgment is rendered in favor of the Plaintiff and the Defendant's Motion for Summary Judgment is denied. The issues in this case having been fully decided, the Permanent Injunction requested by the Plaintiff is also granted and the Defendant is enjoined from denying coverage for high dose chemotherapy, the radiation treatment and the hospitalization associated with such treatment for the Plaintiff's treatment for breast cancer.

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[7] The Court also notes that Blue Cross could very easily have said in the "Therapy Services" section, the section that provides for high dose chemotherapy, "except when administered in conjunction with PSCR or ABMT or other forms of cell rescue."

The Clerk is directed to mail a copy of this Order to all counsel of record.

IT IS SO ORDERED.

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
NORFOLK DIVISION

No. 2:94cv897

MARY BAILEY,

Plaintiff,

v.

BLUE CROSS/BLUE SHIELD OF VIRGINIA,

Defendant.

Filed March 6, 1995

ORDER

CLARKE, District Judge:

The parties have agreed to voluntarily settle the matter, but settlement is contingent upon this court vacating its prior Orders and declaring its prior opinions null and void and of no precedential value. On February 27, 1995, the Plaintiff filed a Motion for Vacatur.[1] The Plaintiff moves the court "to vacate the preliminary injunction, opinion and order previously issued in this case on September 30, 1994 and the permanent injunction, opinion, order and judgment previously issued on October 31, 1994, and all underlying orders entered in this action as being moot and of no effect." The Defendant has indicated to the Court that the above proposed Motion for Vacatur is insufficient and in response,

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[1] The Court notes that the Motion indicates that it was filed jointly; however, the Defendant has since stated to the Court that it does not join in the Motion for Vacatur because it is not satisfactory to the defendant.

the Defendant has submitted a proposed Order for the Court. The proposed Order states:

> this court's preliminary injunction, opinion, order and judgment entered on September 30, 1994 and this court's permanent injunction, opinion, order and judgment entered on October 31, 1994 and all underlying orders are vacated and shall be considered null and void and of no precedential value. The effect of this Order is that the preliminary and permanent injunctions should not be cited, relied upon, or otherwise used in any other case, action, administrative proceeding, appeal or proceeding of any kind by any litigant, party or counsel.

In presenting the motion and the proposed Order to the Court both parties rely on *United States v. Munsingwear*, Inc., 340 U.S. 36, 71 S. Ct. 104, 95 L. Ed. 36 (1950). However, the Court does not find it applicable since *Munsingwear* deals most directly with res judicata and is not in line with the facts of this case. The facts in *Munsingwear* establish that the United States sued Munsingwear, Inc. for alleged violations of a price-fixing regulation and the District Court dismissed the Complaint holding that the respondent's prices complied with the regulation. The United States appealed and while the appeal was pending the commodity involved was decontrolled, and the Court of Appeals dismissed the appeal for mootness. Later, the United States tried to bring another suit regarding the same price-fixing and the Supreme Court affirmed the Court of Appeals that affirmed an order of the District Court dismissing as res judicata a suit by the United States for violation of a price regulation. The Court stated in *Munsingwear*, that

> the established practice of the Court in dealing with a civil case from a court in the federal system which has become moot while on its way here or pending our decision on the

> merits is to reverse or vacate the judgment below and remand with a direction to dismiss. That was said in *Duke Power Co. v. Greenwood County*, 299 U.S. 259, 267 [57 S. Ct. 202, 205, 81 L. Ed. 178 (1936)], "to be the duty of the appellate court."

Id., 340 U.S. at 39-40, 71 S. Ct. at 106-07 (emphasis added). However, in the instant case, the parties are attempting to voluntarily settle this action which is currently docketed with the Fourth Circuit Court of Appeals and it is the parties that are asking the Court to vacate the decision.

The Court finds more guidance in the Supreme Court's recent decision in *U.S. Bancorp Mortgage Co. v. Bonner Mall Partnership*, 115 S. Ct. 386, 130 L. Ed. 2d 233 (1994). In *Bancorp*, the parties entered into a settlement agreement, mooting the merits of case, but one of the parties requested vacation of the Court of Appeals' judgment. The Supreme Court held that it had power to decide the motion to vacate, despite the mooting of the merits of the judgment but that mootness by reason of settlement did not justify vacatur of a judgment under review.

In reaching its decision, the Supreme Court stated:

> Judicial precedents are presumptively correct and valuable to the legal community as a whole. They are not merely the property of private litigants and should stand unless a court concludes that the public interest would be served by a vacatur.

Id., 115 S. Ct. at 392 (quoting *Izumi Seimitsu Kogyo Kabushiki Kaisha v. U.S. Philips Corp.*, 114 S. Ct. 425, 428, 126 L. Ed. 2d 396 (1993) (Stevens, J., dissenting)).

Bancorp does hold that there might be cases when a vacatur could be granted when mootness is produced through settlement. It is an equitable determination and exceptional

circumstances may require such an action. *Id.*, 115 S. Ct. at 393. However, it further states, "[i]t should be clear from our discussion, however, that those exceptional circumstances do not include the mere fact that the settlement agreement provides for vacatur—which neither diminishes the voluntariness of the abandonment of review nor alters any of the policy considerations we have discussed." *Id.* There is nothing in the record to indicate that any exceptional circumstances exist in this case.

The Supreme Court does indicate that the Court of Appeals may remand the case with instruction that the district court consider the request, pursuant to Federal Rule of Civil Procedure 60(b). Although the case has not been remanded by the Fourth Circuit Court of Appeals, this Court has considered the motion presented by the plaintiff and the proposed Order presented by the defendant and FINDS that vacatur is not appropriate as proposed above. The Court further notes that it had suggested and offered to vacate the judgment order including the portion providing for the permanent injunction and to enter an Order reciting the settlement and dismissing the case with prejudice; however, the defendant did not find that satisfactory.[2]

Therefore, the Motion for Vacatur and the proposed Order are both DENIED.

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[2] The Court notes that its opinion and judgment had already been published in advance sheets prior to the request of the parties recited herein. *See Bailey v. Blue Cross/Blue Shield of Va.*, 866 F. Supp. 277 (E.D. Va. 1994). Further, the publisher advised the Court that the judgment and opinion was in the bindery being incorporated into a hard back volume. The motions of the parties came too late to prevent publication.

The Clerk is DIRECTED to send a copy of this Order to all counsel of record.

IT IS SO ORDERED.